M I S S O U R I

DEPARTMENT OF MENTAL HEALTH

Annual Safety Report

Submitted to Governor Jeremiah W. (Jay) Nixon
June 30, 2009

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

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June 30, 2009

Governor Jeremiah W. (Jay) Nixon
Lieutenant Governor Peter Kinder
Missouri Mental Health Commission

Re: 2009 Annual Report on Implementation of Safety Recommendations

Dear Governor Nixon, Lieutenant Governor Kinder and Commissioners:

The Department of Mental Health (DMH) is pleased to present its Annual Report outlining this year's progress toward the safety recommendations of the 2006 Mental Health Task Force (MHTF). In preceding reports, DMH documented timely success in completing a large majority of the recommendations, giving the Department additional tools in responding to incidents of DMH consumer abuse and neglect. Implementation of the recommendations has provided instructive data for future development efforts, including prevention strategies, to deter abuse and neglect and avoid harm to DMH consumers.

The safety agenda put forth in the 2006 Mental Health Task Force report has essentially been accomplished. The Department recognizes that safety is a job that is never marked "complete" and continued vigilance and systemic attention to safety concerns will be necessary. Safety-related thresholds, trends and risk indicators will be monitored by DMH staff and necessary action will be taken when either safety risks or opportunities for improvement are identified. Implementation of the action steps recommended by the MHTF is an important milestone and demonstrates the commitment of concerned DMH leadership and hard work of many department staff assigned to safety-related efforts.

Sincerely,

Lynn Carter

Lynn Carter, MSW, LCSW
Deputy Director

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19 The Department of Mental Health is pleased to report that the Mental Health Task Force recommendations have essentially been completed or have been integrated into ongoing quality assurance and improvement processes to maintain sustained commitment to consumer safety. Future annual reports will be redesigned to provide a "snapshot" of DMH safety indicator data as a tool for governmental transparency and accountability.

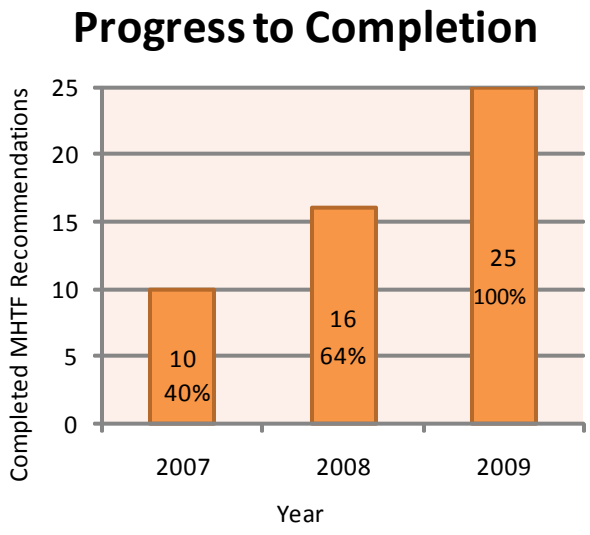
Executive Summary

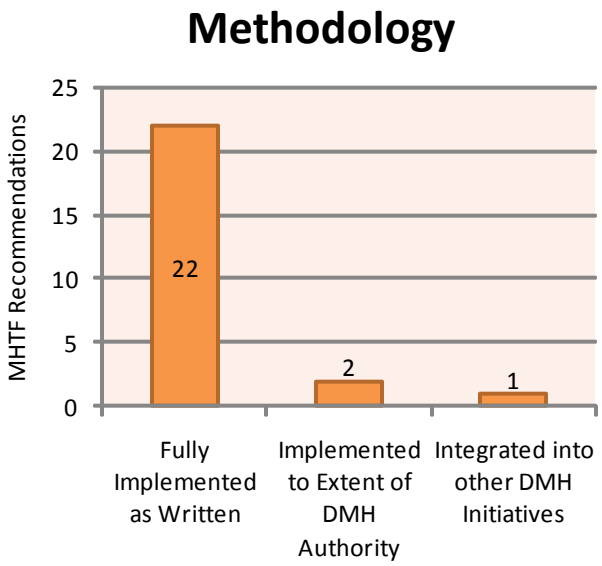
The Department of Mental Health (DMH) has diligently pursued responsibilities to carry out the action steps as outlined in the 2006 Mental Health Task Force (MHTF) report to improve consumer safety. In three years of dedicated attention to these recommendations, DMH has completed the work necessary to operationalize the safety agenda set forth by the Task Force. In the last three years, key accomplishments include:

- Expanded opportunities for reporting abuse and neglect of DMH consumers;
- Improved responsiveness, efficiency and quality of DMH investigations;
- Incorporated death reviews as an important quality assurance tool;
- Added regulatory tools to enforce safety requirements and stiffer penalties for those who cause harm to DMH consumers; and,
- Increased DMH transparency and accountability to DMH consumers, families, and other stakeholder groups.

The completion of this work represents a significant milestone for the Department and its stakeholders. The hard work and dedication of many DMH staff has been required to rebuild trust with consumers and their families and to demonstrate vigilance and commitment to protecting consumers from harm while receiving services from DMH and its provider systems.

The chart below provides a summary of DMH progress to completion and implementation methodologies for the twenty-five (25) MHTF recommendations.





Protecting the well being of DMH consumers is a job that is never done. Protection from harm requires ongoing attention and vigilance through institutionalized quality management processes that monitor safety indicators, identify problems early and institute immediate corrective actions. Strong quality improvement systems also challenges the organization to identify needed improvements to deter and prevent consumer harm and minimize safety risks. DMH is committed to the difficult work that remains to be done to further protect and promote consumer safety.

Introduction

Purpose of Report

As the final recommendation in its November 2006 report, the Mental Health Task Force (MHTF) mandated the creation of an annual safety report to be prepared by the Missouri Department of Mental Health (DMH). The annual report, due each year on June 30, is to be submitted to:

- The Governor;
- The Lt. Governor; and
- The Mental Health Commission (MHC).

Its purpose is to summarize DMH progress in implementing twenty-five (25) safety-related MHTF recommendations.

Background Information

In 2006, public concern emerged about safety for DMH consumers. A Governor-appointed task force was convened as the Mental Health Task Force and was given the charge to review best practices and make recommendations for changes to the mental health system that would result in improved safety for DMH consumers. The MHTF sponsored a series of meetings and offered the opportunity for public testimony at six locations across the state where nearly 300 Missouri citizens stepped forward to make their voices heard. After months of public dialogue and careful deliberation, the MHTF issued its report in November 2006. The full report is available for public review at http:\\www.dmh.missouri.gov\mmhtaskforce\index.htm.

In the 2007 session, the Missouri legislature passed a bill outlining a series of important measures designed to promote safety for those participating in services provided or purchased by DMH. The legislation was successfully passed on May 18, 2007, and became law on August 28, 2007. Interested readers can learn more about the bill in its final form at http:\\www.senate.mo.gov\07info\pdf-bill\tat\SB3.pdf.

As recommended by the MHTF, the first Annual DMH Safety Report was submitted in 2007 followed by the second report on June 30, 2008. These reports continue to be available for public review on the DMH website at http:\www.dmh.mo.gov\spectopics\DMHSafetyReports.htm. The 2009 report will also be posted to the DMH website after its submission to the Governor.

Implementation Progress for MHTF Recommendations

2009 Overview of Strategic Process

Through dedicated and sustained leadership, commitment and attention to the safety recommendations made by the MHTF, the Department can report that it has essentially completed necessary action steps to establish systemic mechanisms and safeguards that will provide safety protections to DMH consumers. This report documents the dedicated effort of many department staff and paves the way for sustained organizational commitment of the Department to "do no harm," an important guiding premise for all health care delivery systems.

This section of the annual report summarizes implementation detail for each recommendation in a consistent format that includes the full text of the recommendation, a dot-point listing of milestones in Fiscal Year 2009, and a progress status icon with the year work was completed.

Recommendation # 1: Accreditation of MRDD Facilities and Programs

Full Recommendation	
The Department of Mental Health shall pursue survey readiness towards national accreditation of its six habilitation centers and contracted community providers serving persons with developmental disabilities.	
2009 Update	**Status**
Habilitation Centers • Habilitation Center readiness has been substantially enhanced since 2006 and continued leadership attention has resulted in increased use of state of the art quality management principles and tools in their operations. • The Division of Developmental Disabilities* has developed and will continue to utilize quality assurance systems and methods such as mortality review, risk management protocols, essential safeguards system review, national core indicators, and other tools for reducing safety risks and improving quality and consumer safety outcomes. • The Division of Developmental Disabilities has added key clinical leadership to work with facilities and community providers, such as nurse executives, behavioral analysts, training and employment specialists, and other relevant expertise. • Fiscal Year 2010 core budget reductions will result in conversion of two habilitation centers to state-operated independent supported living settings subject to different regulations and standards for services and operations. ***Community Providers*** • Human Services Research Institute report regarding community accreditation is posted at http://www.dmh.mo.gov/mrdd/Accreditation%20CARF/accreditationreport08.pdf. • The Division of Developmental Disabilities has provided information and technical assistance to promote accreditation among community providers.	 2009

*By Executive Order 08-35, the Division of Mental Retardation and Developmental Disabilities became known as the Division of Developmental Disabilities.

Recommendation # 2: Formal Ties with Hotlines

Full Recommendation
The Department of Mental Health shall work with the Department of Health and Senior Services to establish formal ties to its adult abuse hotline, and with the Department of Social Services for formal ties to its child abuse hotline, so reporters of abuse and neglect of DMH consumers fully utilize those hotlines as another means of reporting abuse and neglect. The Department shall then rigorously promote the use of these hotlines.

2009 Update	Status
• Completed in Fiscal Year 2008 • Sustaining efforts	 2008

Recommendation # 3: Training for Consumers and Families

Full Recommendation
The Department of Mental Health and community providers shall develop standard individualized training for consumers and families on identifying and reporting abuse and neglect, including their responsibilities as permissive reporters.

2009 Update	Status
• The Department of Mental Health Director has posted an important message to stakeholders, families and consumers http://www.dmh.mo.gov/diroffice/ReportingAbuseandNeglect.htm. • The brochure developed in 2008 by the Office of Consumer Safety (OCS), in conjunction with the program Divisions, was: o Modified for community settings o Broadly disseminated to facilities and community providers o Posted in written format on the DMH website and available to print at http://www.dmh.mo.gov/opa/pubs/Safetybrochure.pdf and in video form on the Network of Care at http://cole.mo.networkofcare.org/mh/multimedia/consumersafety.cfm. • Developmental disability self-advocates conducted a series of training sessions in Division of Developmental Disabilities facilities to provide self-advocacy skills related to consumer safety.	 2008

RECOMMENDATION # 4: STANDARDIZED TRAINING

Full Recommendation
The Department of Mental Health shall amend its Departmental Operating Regulations (DORs) and administrative rules to require standardized training based on best practices for all DMH and provider staff on identifying and reporting abuse and neglect. Law enforcement expertise should be utilized in the development of such training. The Department of Mental Health shall also standardize training protocol for investigators that includes review of policies and procedures, supervision levels, and training on the Safety First manual. The Department shall implement a mentoring program for new investigators that will include teaming them with seasoned investigators.

2009 Update	Status

• DMH Human Resources managed an ongoing implementation work group that:
  o Developed extensive training content for the DMH e-Learning catalogue, including responsibilities for reporting abuse and neglect;
  o Implemented a comprehensive e-Learning orientation and basic training for direct care staff in DMH facilities with an emphasis on safety; and
  o Provides an ongoing mechanism to disseminate training content related to safety and other service delivery concerns.
• Investigations Unit director and supervisors continue to invest in quality investigative skills through ongoing Reid and LRA training, both basic and advanced, consistent with the investigator's experience.
	
	2008

Recommendation # 5: Redesign of DMH Licensure and Certification

Full Recommendation
The Department of Mental Health shall redesign its process for licensure and review of community-based providers within the next 12 months. The process should include a review of best practices from other states. Annual site visits to facilities should be mandatory. Part of this process should include routine communication between the Investigative Unit and the Division of MRDD so that facilities with increased numbers of allegations can be targeted for additional assistance in maintaining consumer safety.

2009 Update	Status
Working with resource constraints within the Licensure and Certification Unit, the Division of Developmental Disabilities included the intent and components of the recommendation within the re-design of its regional office structure, including it in the quality assurance system.	 2009

Recommendation # 6: Penalties for Failure to Implement Plans of Correction

Full Recommendation
The Department of Mental Health shall pursue legislation and amend regulations involving Licensure and Certification to permit administrative actions, up to and including fines, for failure to implement plans of correction.

2009 Update	Status
Plan in place to create the authority through administrative rules for Licensure and Certification to penalize providers who are in violation of this provision.	 2009

Recommendation # 7: Penalities for Failure to Report Abuse and Neglect

Full Recommendation	
The Department of Mental Health shall pursue legislation and amend regulations that permit fines or other penalties against licensed, certified, or contracted entities for failure to report abuse and neglect, based upon organizational misconduct.	
2009 Update	**Status**
Plan in place to create the authority through administrative rules for Licensure and Certification to penalize providers who are in violation of this provision.	 2009

Recommendation # 8: Enhance Direct-Care Salaries

Full Recommendation	
The Department of Mental Health must improve the quality of care by enhancing the salaries of direct care staff to be commensurate with the level of skill and responsibility required of those positions in both state operated and community based care.	
2009 Update	**Status**
• DMH plans to continue to work diligently with the Governor's Office, the Personnel Advisory Board and the legislature to appropriately compensate DMH direct care staff in order to provide continuity of care with a skilled and compassionate direct care workforce. • DMH has developed strategies to promote provider rate increases commensurate with state employee advances. • In order to maintain attention to this important issue, salary and benefits to direct care staff as well as turnover, injury, vacancy and overtime indicators will be explored as status indicators in future safety reports.	 2009

Recommendation # 9: Data and Quality Improvement

Full Recommendation
The Department of Mental Health must implement an information management system that can rapidly and effectively track critical data on abuse, neglect, and other safety information. This data will be used as a component of the Department's continuous quality improvement plan and the Department's annual report to the Governor and Lieutenant Governor. Additionally, information technology should be developed to integrate all state departments' data for tracking any facility related inspections, complaints, investigations, etc., for both public and community based care.

2009 Update	Status
• Completed in Fiscal Year 2008 • Sustaining efforts	 2008

Recommendation # 10: Root Cause Analysis

Full Recommendation
The Department of Mental Health shall review completed investigations and explore Root Cause Analysis (RCA) for complaints and issues which are recurring. Root Cause Analysis should include, but not be limited to: examination of supervision levels and staffing and identification of facility system failures for both public and community based care.

2009 Update	Status
• RCA continues to be used in Joint Commission accredited CPS facilities for all Joint Commission reportable critical incidents. • All divisions are using RCA as a component of the Division death review process for deaths that meet established criteria. • RCA is a source of information for the DMH Fatality Review Panel.	 2009

Recommendation # 11: Real Choices and Range of Services

Full Recommendation
The Department of Mental Health shall make a clear and unequivocal commitment to providing public and community based services that afford real choices for all Missourians who require DMH services. Because it is recognized that various types of care are needed for different individuals, the Department shall provide services on a person by person basis.

2009 Update	Status
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

Recommendation # 12: DMH Commitment to Safety

Full Recommendation
The Department of Mental Health shall review its policies and procedures, and ensure that the health, safety, and welfare of all its consumers are the first and foremost priorities of all employees -- investigators as well as the clinical staff -- of the Department. The Department's complaint investigation procedures need to be evaluated for effectiveness (including the benefits of allowing unannounced investigations) and a system put into place whose primary role is to assist in the prevention of abuse and protection of consumers through the investigation of abuse, neglect and misuse of funds.

2009 Update	Status
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

Recommendation # 13: Additional Background Checks

Full Recommendation
The Department of Mental Health shall amend its regulations to create a process to require providers to conduct background checks on all potential employees to determine whether the individual is the subject of a pending investigation or finalized abuse or neglect case involving disqualifying events and require the provider to take appropriate steps to provide consumer safety.

2009 Update	Status
• Completed in Fiscal Year 2008 • Sustaining efforts	 2008

Recommendation # 14: Civil Immunity for Employer Discussion of Performance

Full Recommendation
The Department of Mental Health shall pursue legislation providing civil immunity to providers and DMH administrators allowing open discussion of individual job performance in order to make employment decisions that affect the safety of consumers. However, the legislation shall not protect reckless, misleading communication or intentional misstatements.

2009 Update	Status
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

Recommendation # 15: Death Review Record

Full Recommendation
The Department of Mental Health shall craft a legislative proposal comparable to that which created Child Fatality Review Boards within the Department of Social Services. It would establish review of all deaths of adults who are in the care and custody of the Department of Mental Health. The board should include the expertise of pathologists or medical examiners, law enforcement, prosecutors, and advocates, including Missouri Protection & Advocacy Services.

2009 Update	Status
• Effective January 1, 2009, all consumer deaths are thoroughly reviewed at the Division level using standardized protocols and reviews are submitted to the Deputy Director for additional review. • A uniform data set is being collected for all consumer deaths to support data analytics and risk prediction modeling. • Department-wide Fatality Review Panel (FRP) has been appointed and has convened on a quarterly basis since October 2008. • FRP administrative rules are in the development phase with filing planned for Summer 2009.	 2009

Recommendation # 16: Public Access to Final Reports Substantiating Abuse and Neglect

Full Recommendation
The Department of Mental Health shall pursue legislation to allow public access to non-confidential information in final reports of substantiated abuse and neglect.

2009 Update	Status
• Statutory requirement became effective August 28, 2007. • Substantiated reports are released in compliance with statutory requirement.	 2008

Recommendation # 17: Process Improvements for DMH Investigations Protocols

Full Recommendation
The Department of Mental Health shall develop a process for triage of incidents for joint investigation of all deaths or near deaths that are suspect for abuse or neglect, as well as incidents of physical assault and sexual misconduct. In order to conduct "triage," strict procedural guidelines must be developed to allow for proper prioritizing of cases. This process should include notification of and cooperation with local law enforcement.

2009 Update	Status
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

Recommendation # 18: Administrative Disciplinary Procedures

Full Recommendation
The Department of Mental Health and providers must ensure that incidents not impacting consumer safety as defined and enforced by Department policy are handled administratively through disciplinary procedures — though still tracked in the Department's information systems and monitored by executive staff. This would allow investigators to improve consumer safety by dedicating themselves to harmful incidents of abuse or neglect.

2009 Update	Status
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

Recommendation # 19: Sister Agency Investigations Improvement Recommendations

Full Recommendation	
The Department of Mental Health shall enhance its investigations process by evaluating recommendations from the sister agencies on this Task Force and implementing all that are feasible.	
2009 Update	**Status**
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

Recommendation # 20: DMH Investigation Resources

Full Recommendation	
The Department of Mental Health shall evaluate the number of investigations completed by the Investigations Unit and determine the appropriate number of investigators needed in order to meet current mandated time frames, without sacrificing the quality of the investigation. Interviews shall be initiated within the first day of the investigation.	
2009 Update	**Status**
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

Recommendation # 21: Implement Mental Health Commission Recommendations

Full Recommendation
The Department of Mental Health shall work with the Mental Health Commission to implement the Commission's recommendations to the fullest extent possible.

2009 Update	Status
• Safety related recommendations were implemented as priorities. • The additional recommendations in the report represent long term development and change efforts. After careful review, these have been sorted into two categories for development: o Integrated into Mental Health or Developmental Disabilities Transformation efforts, such as the planning for mental health needs of aging Missourians, flexible funding, or use of natural supports; o Included in budget development discussions for consideration as DMH decision items in the DMH budget, such as crisis intervention traning and drug courts, and will only be implemented if resources are available.	 2009

Recommendation # 22: Update Agreement with Missouri Protection and Advocacy

Full Recommendation
The Department of Mental Health's Memorandum of Understanding (MOU) with Missouri Protection & Advocacy Services shall be reviewed and amended if necessary to clarify roles and expectations. The terms of the MOU shall be made broadly available and become part of orientation and annual training for employees, consumers, and families.

2009 Update	Status
• Agreement signed March 2009	 2009

Recommendation # 23: Pursue Legislation Similar to Elder Abuse

Full Recommendation	
The Department of Mental Health shall pursue legislation to amend Sections 565.180, RSMo, et. seq., which pertains to the crime of elder abuse, to incorporate the crime of patient, resident, or client abuse or neglect of a Department consumer currently provided for in Section 630.155, RSMo.	
2009 Update	**Status**
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

Recommendation # 24: Public/Private Partnerships for MRDD Case Management

Full Recommendation	
The Department of Mental Health, Division of Mental Retardation/Developmental Disabilities (MRDD), shall create a committee of key stakeholders to evaluate the feasibility of public-private partnerships to deliver case management services, determine eligibility, manage local wait lists, and provide and/or contract for a system of programs and services in their local areas.	
2009 Update	**Status**
• Completed in Fiscal Year 2007 • Sustaining efforts	 2007

RECOMMENDATION # 25: ANNUAL SAFETY REPORT

Full Recommendation
The Department of Mental Health shall prepare an annual report to the Governor, the Lieutenant Governor, and the Mental Health Commission on its progress in implementing these recommendations. It shall include data that indicates the level of safety in the mental health system, along with plans for additional action where needed. The first report shall be submitted on or before June 30, 2007.

2009 Update	Status
• 2007 report submitted July 2, 2007 • 2008 report submitted June 30, 2008 • 2009 report submitted June 30, 2009	 2007 - 2009

Conclusion

By completing the safety agenda laid out in the 2006 Mental Health Task Force report, the Department of Mental Health can celebrate the milestone accomplishments it represents while recognizing more work lies ahead. In the last three years, key accomplishments include:

- Expanded opportunities for reporting abuse and neglect of DMH consumers;
- Improved responsiveness, efficiency and quality of DMH investigations;
- Incorporated death reviews as an important quality assurance tool;
- Added regulatory tools to enforce safety requirements and stiffer penalties for those who cause harm to DMH consumers; and,
- Increased DMH transparency and accountability to DMH consumers, families, and other stakeholder groups.

Protecting the well being of DMH consumers is a job that is never done. Protection from harm requires ongoing attention and vigilance through institutionalized quality management processes that monitor safety indicators, identify problems early and institute immediate corrective actions. Strong quality improvement systems also stretch the organization to identify needed improvements to deter and prevent consumer harm and minimize safety risks. DMH is committed to the difficult work that remains to be done to further protect and promote consumer safety including:

- Continued monitoring of safety indicators for DMH consumers and implementing corrective action when necessary;
- Developing prevention and mitigation strategies through systemic quality improvement efforts;
- Improving training and other tools to assure that every therapeutic interaction between every staff person and every DMH consumer promotes safety, trust and recovery;
- Enhancing recruitment and retention strategies that result in adequate numbers of a qualified direct care workforce and clinical specialty staff, all of whom recognize their roles and responsibilities in protecting DMH consumers from harm; and,
- Challenging DMH systems to increase transparency of quality and performance information for DMH consumers and their families.

The Department has recognized the value of the annual safety report as one tool for transparency and accountability to its stakeholder communities. In 2010 and subsequent years, the report will evolve into a format that provides consumer safety information through status updates on key safety indicators. The safety indicators will be chosen to be high level systemic indicators for continued commitment to safety and will be rooted in the key themes of the MHTF recommendations designed to create a safety culture such as:

- Direct care staff workforce development;
- Effectiveness and responsiveness of DMH abuse and neglect investigations;
- Consumer safety outcomes; and,
- Death reviews as a systemic quality improvement tool.

A work team will be convened in July 2009 to begin efforts to design the report and compile data to serve as a DMH "safety report card" and to maintain ongoing systemic focus on consumer safety. As the Department embraces its responsibility as a service system to first, "do no harm," the Department must measure and report its progress and successes in protecting consumers from harm. In addition, when the system fails to prevent abuse or neglect, the Department must have systems in place to learn from those failures. The Department intends to honor the trust of DMH consumers through renewed commitment to its first and greatest responsibility to provide safe environments that give people the opportunity to pursue their dreams and live their lives as valued members of their communities.

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